- What medical condition are you concerned about?
  - Asthma
  - Allergies
  - Heartburn/GERD
  - COPD

- Sex: M------ F----------

- Year of birth: ----------

- Please list your approximate height and weight:---------ft in -------- lbs

- Do you have any of the medical conditions listed below?
  - Arthritis
  - Asthma
  - Cancer
  - Diabetes
  - Heart disease
  - High Blood Pressure
  - Kidney Disease
  - Liver Disease
  - Psychiatric Disorder

- Do you take any of the medications listed below?
  - Anti-viral medication
  - Cholesterol medication
  - Diabetes medication
  - Heartburn medication
  - High blood pressure medication
  - Hormones
  - NSAIDs (non-steroidal anti-inflammatory drugs)
  - Pain Relievers
  - Steroids
  - Thyroid medication

- Do you smoke cigarettes/cigars? Yes-------No----------

- Please list your contact information so we can contact you about participating in a clinical trial:

  - Name:
  - Address:
  - Email address:
  - Phone: